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10/93 i. For hospitals that do not meet the definition of a DSH hospital under Sections C.1.a.through C.1.e. of Chapter VI. in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of one year; and

10/93 ii. For hospitals defined by the Department as DSH hospitals under Sections C.1.a. through C.1.e. of Chapter VI. in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of six years.

d. "Rate for services provided" means the inpatient rate in effect for the type of services provided.

10/93 e. "Total covered charges" means the amount entered on the UB-82 or UB-92 Uniform Billing Form for revenue code 001 in column 53 (Total Charges).

09/91 G. Filing Cost Reports

==07/95 1. All hospitals in Illinois, those hospitals in contiguous states, providing 100 or more inpatient days of care to Illinois program participants, and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the DRG PPS, shall be required to file Medicaid cost reports within 150 days of the close of the provider's fiscal year and submit a copy of the filed Medicare report.

==07/95 2. No extension of the due date will be granted by the Department.

10/93 3. The assessment or license fees mandated by Public Acts 87-13, 87-861, and 88-88 may not be reported as allowable Medicaid costs on the Medicaid cost report.

10/93 4. For a hospital that is electing to participate in the Illinois Medicaid Program and has not filed a Medicaid cost report before, the hospital must submit the two most recently audited Medicare cost report at the time of enrollment.

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09/91 H. Transition to the Diagnosis Related Grouping Prospective Payment System (DRG PPS)

10/93 1. Effective with admissions occurring on or after September 1, 1991, and before October 1, 1992, hospitals shall be reimbursed in accordance with the State plan governing the time period when the services were provided.

10/93 2. Effective with admissions occurring on or after October 1, 1992, hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act (Ill. Rev. Stat. Ch. 23, Par. 6505-1 et seq.) and that elected, effective September 1, 1991, to be reimbursed at rates stated in such contracts, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care, in accordance with Section I. of this Chapter.

==07/95 3. In the case of a hospital that was determined by the Department to be a rural hospital at the beginning of the rate period described in Section B.2.a. of Chapter XVI., those hospitals that shall be treated as sole community hospitals, as described in Section B.1. of Chapter VI., shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services during the rate period described in Section B.2.a. of Chapter XVI.:

a. the DRG PPS, as described in Chapters IV. and VII., or

b. the rate calculated under Section A. of this Chapter.

10/93 4. In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section B.2.a. of Chapter XVI., but was subsequently reclassified by the Department as a rural hospital, as described in Section B.3. of Chapter XVI., on July 14, 1993, those hospitals that shall be treated as sole community hospitals, as described in Section B.1. of Chapter VI., shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided on October 1, 1993, and for the duration of the rate period described in Section B.2.a. of Chapter XVI.:

10/93 a. The DRG PPS, as described in Chapters IV. and VII., or

10/93 b. The rate calculated under Section A. of this Chapter.

09/91 I. Annual Irrevocable Election

10/92 1. The hospitals described in Sections H.2. and H.3. above, may elect to be reimbursed under the special arrangements described in Sections H.2. and H.3. above at the beginning of each rate period.

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==07/95 2. Hospitals described in Sections H.2. through H.4. above may elect to be reimbursed under the special arrangements described in Sections H.2. through H.4. above effective with admissions, or, if applicable, with inpatient services provided, on October 1, 1993, and for the duration of the rate period described in Section B.2.a. of Chapter XVI.

==07/95 3. Hospitals described in Section H.4. above may elect to be reimbursed under the special arrangements described in Section H.4. above at the beginning of each rate period described in Section B.2.b. of Chapter XVI.

10/93 4. Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that rate period elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that rate period elect to be reimbursed under the DRG PPS.

10/93 5. Hospitals, that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care. Once such election has been made, the hospital may not later in that rate period elect to be reimbursed under any other methodology.

10/93 6. Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be reimbursed under the DRG PPS may not later elect to be reimbursed at rates stated in such contracts.

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10/92 J. Notification of Reimbursement Methodology.

10/92 1. Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring during the rate period.

10/93 2. Hospitals described in Sections H.2. through H.4. above shall receive notification of their reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in Sections H.2. through H.4. above shall have thirty (30) days from the date of such notification to file, with the Department, the reimbursement method of choice for the rate period. In the event the Department has not received the hospital's Choice of Reimbursement form within thirty (30) days from the date of notification, as described above, the hospital will automatically be reimbursed for the rate period under the reimbursement methodology that would have been in effect without benefit of the election described in Section I. above.

09/91 K. Pre-September 1, 1991 Admissions.

Reimbursement to hospitals for claims for admissions occurring prior to September 1, 1991, will be calculated and paid in accordance with the statutes, administrative rules, waivers, and state plans governing the time period when the services were rendered.

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10/92 L. Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements

10/92 1. Utilization Review

10/92 The Department, or its designee, may conduct preadmission, concurrent, prepayment, and postpayment reviews of:

10/93 a. The quality and nature of the utilization of health services;

10/93 b. The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under outlier provisions;

10/93 c. The validity of the hospital's diagnostic and procedural information;

10/93 d. The completeness, adequacy and quality of the services furnished in the hospital; or

10/93 e. Other medical or other practices with respect to program participants or billing for services furnished to program participants.

10/92 2. Medical Review Notification

10/92 Hospitals shall be notified at least thirty (30) days in advance of any preadmission, concurrent, or prepayment review requirements imposed by the Department.

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10/92 3. Prepayment Review

10/92 The Department may require hospitals to submit claims to the Department for prepayment review and approval prior to rendering payment for services provided. Such prepayment review requirements will be focused on areas where the Department has substantial reason to suspect abuse (e.g., hospital billings deviate from the norm). The review may be conducted by the Department or its designated peer review agents. Prepayment review shall be used to determine the appropriateness and medical necessity of the inpatient stay. Payment shall not be made unless the medical necessity of the inpatient stay can be documented. The Department shall notify the hospital by letter or Department Informational Notice of the designated services which shall be subject to prepayment review. The prepayment review requirement shall commence thirty (30) days after the Department has given notice to the hospital of the designated services which shall be reviewed.

10/92 4. Postpayment Review

10/92 Postpayment review shall be conducted on a random sample of hospital stays following reimbursement to the hospital for the care provided. The Department may also conduct postpayment review on specific types of care.

10/92 5. Hospital Utilization Control

10/93 Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Section C.1. of Chapter II. of this plan, shall be in accordance with federal regulations in 42 CFR, Ch. IV, Part 456, Subpart G (October 1, 1991).

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10/92 6. Denial of Payment as a Result of Admissions, Length of Stay, Transfers and Quality Review

a. If the Department determines that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

i. Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission or transfer of an individual.

ii. Require the hospital to take action necessary to prevent or correct the inappropriate practice.

iii. Perform prepayment review in accordance with Section L.3. above.

10/92 b. When payment with respect to the discharge of an individual patient is denied by the Department, or its designee, under Section L.6.a.i. of this Chapter, a reconsideration will be provided within 30 days, upon the request of a practitioner or provider, if such request is the result of the designee's own medical necessity or appropriateness of care denial determination and is received within 60 days of the Advisory Notice. The date of the Advisory Notice is counted as day one.

10/92 c. A determination under Section L.6.a. of this Chapter, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:

i. Withholding Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

ii. Termination of the hospital's Provider Agreement.

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10/93 7. Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

==07/95 a. The applicable payments made under Chapters VI., VIII., X., XIII., XIV. and XVII are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described below.

10/92 i. Hospital-based physicians who may not bill separately on a fee for service basis:

10/92 A) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.

10/92 B) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

10/92 ii. Hospital-based physicians who may bill separately on a fee-for-service basis:

10/92 A) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.

10/92 B) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

10/92 C) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

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10/92 D) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.

10/92 E) A physician holding a nonteaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

04/94 b. Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

09/91 M. Reductions to total payments, as described in Section E. of Chapter VII., shall apply regarding copayments and third party payments.

==07/97 N. All per diem payments calculated under Sections A, B, C, D, and F above, in effect on January 18, 1994, less the costs attributed to medical education, shall remain in effect ~~until June 30, 19967.~~ hereafter.